Veteran's Affairs (VA)
Department of Defense (DoD)
Uncomplicated Pregnancy (UCP)

Clinical Practice Guideline (CPG)

Satellite Broadcast Syllabus

10 December 2002

Dedicated to COL Michael Yancey

29 May 1959 — 27 January 2002

- Former Chief, Prenatal Services, Tripler Army Medical Center
  Honolulu, HI
- Uncomplicated Pregnancy Clinical Practice Guideline Expert

Objectives

- Identify the rationale for development and implementation of the DoD/VA Clinical Practice Guideline for the Management of Uncomplicated Pregnancy.
- Identify key elements of the DoD/VA Clinical Practice Guideline for the Management of Uncomplicated Pregnancy.

Objectives

- Discuss quality of care metrics in the obstetrical arena.
- Discuss the use of provider, patient tools that have been developed to facilitate the implementation of the DoD/VA Guideline for the Management of Uncomplicated Pregnancy.
- Analyze strategies for implementation of the DoD/VA Guideline for the Management of Uncomplicated Pregnancy for use in your setting.

Agenda

- “Why” – Rationale
- “What” – CPG Key Elements
- “How” – Implementation
- Metrics
- Tools
- OB Initiatives
- Marketing
- Questions & Answers

Dr. David Tornberg

- Defense Authorization Act 2002
- Obstetrical numbers significant
- Women’s role as main purchaser of health care
- Quality equals patient satisfaction
- Reduce unwanted variance
- Cutting edge care

Dr. Susan Mather

- 1.4 million women veterans
- Over 275,000 enrolled for VA care
- 50% are under age 45
- VA provided maternity benefits
- CPGs: set standard and serve as benchmark

Why?

- Antenatal care is one of the largest services in Military Health Care System
- Current antenatal care is steeped in traditionalistic practices
- Consumerism in obstetrics associated with new defense bill
- Increasing importance of patient satisfaction

Goal of Uncomplicated Pregnancy Clinical Practice Guidelines

- Decrease unwanted variance:
  - Leading dissatisfier for patients
  - Viewed as an indicator of poor quality of care

Quality of Care

- Number 1 concern of health care consumers
- Equates to satisfaction in eyes of health care consumers

Key Principle of Guideline

- Change from the traditional interval-based visit
- Guideline recommends specific *gestational age visits*, each having well-defined goals & objectives
  - 6-8 Weeks
  - 10-12 Weeks
  - 16-20 Weeks
  - 24, 28, 32 and 36 Weeks
  - 38-41 Weeks

Key Elements

- Standardized:
  - Counseling for Antepartum diagnostic screening
  - Prenatal care
  - Care Plan
  - Education of provider and patient

Key Elements

- Explicit, evidence-based intervention for screening and management
- Tool kit
  - Provider
  - Patient
  - Clinic

Standardized Counseling

- Includes:
  - Cystic Fibrosis Carrier Screening
  - Maternal Serum Analyte Screen
  - HIV Testing
- Patient Education
- Patient Screening
- Availability of counseling and follow-up
- Standardized timing of above

Standardized Screening

- Assesses appropriateness of patient placement on Uncomplicated Pregnancy Clinical Practice Guideline
- Includes
  - Initial screening
  - Repeat screening (pre-term labor, abuse and other high risk factors)

Standardized Prenatal Care

- Prenatal Care Matrix
- Designed with provider in mind to improve effectiveness and efficiency of care
- Improves consistency of care
- Helps to assure all essential components of care are covered at appropriate time

Standardized Prenatal Care Plan

- Designed with patient in mind to improve satisfaction with prenatal care
- Decrease variability between providers, facilities, and services
- Help the patient be more prepared for her visit

Standardized Education for Provider and Patient

- Education is considered the backbone of prenatal care
- Goal Oriented Visits specify what education is needed and when it is most appropriate
- Both provider and patient know what and when education is provided

Explicit, Evidence-Based Intervention

- Expert panel
- Scrutinized each element of traditional prenatal care
- Graded interventions having adequate scientific foundation
- Consensus decision made if lack of evidence of benefit or negative cost-effective analysis

Rating the Evidence

- Quality of Evidence
  - I, II-1, II-2, II-3, III
- Overall Quality
  - Good, Fair, Poor
- Net Effect of the Intervention
  - Substantial, Moderate, Small, Zero or Negative
- Overall Recommendation
  - A, B, C, D, I

Quality of Evidence

- **I** at least 1 properly done randomized clinical trial
- **II-1** well designed controlled trial without randomization
- **II-2** well designed cohort or case-control analytic study
- **II-3** multiple time series, dramatic results of uncontrolled experiment
- **III** opinion of respected authorities, case reports and expert committees

Overall Quality

- **Good**: high grade evidence (I or II-1) directly linked to health outcome
- **Fair:** high grade evidence (I or II-1) linked to intermediate outcome OR moderate grade evidence (II-2 or II-3) directly linked to health outcome
- **Poor:** Level III evidence or no linkage of evidence to health outcome

Net Effect of the Intervention

- Substantial: More than a small relative impact on a frequent condition OR a large impact on an infrequent condition with a significant impact on the individual patient level
- Moderate: A small relative impact on a frequent condition with a substantial burden or suffering OR A moderate impact on an infrequent condition with a significant impact on the individual patient level
- Small: A negligible relative impact on a frequent condition with a substantial burden of suffering OR a small impact on an infrequent condition with a significant impact on the individual patient level
- Zero/Negative: Negative impact on patients OR no relative impact on either a frequent condition with a substantial burden of suffering OR an infrequent condition with a significant impact on the individual patient level

Overall Recommendation

- **A:** a strong recommendation that the intervention is always indicated and acceptable
- **B:** a recommendation that the intervention may be useful/effective
- **C:** a recommendation that the intervention may be considered
- **D:** a recommendation that a procedure may be considered not useful/effective or may be harmful
- **I:** insufficient evidence to recommend for or against-the clinician will use clinical judgment

Intervention	QE*	Overall Quality	Recommendation
BP screen at each visit	III	Good	B
Auscultation of FHT	III	Poor	C
Regular exercise	I	Good	A
Repeat ABS at 28 wks	III	Poor	I
Selective iron supplementation	I	Good	B

* Quality of Evidence

Reference Info

Omitted Routine Care Processes

- Urine dipstick at every visit
- Clinical antenatal pelvimetry
- Edema evaluation at every visit
- Labs after 20 weeks (except:1 hr Glucola)
- Vitamin supplementation
- Immunization: MMR, Varicella
- Ultrasound evaluation of cervical length
- Cervical exams

Care Processes Not Recommended

- **Screening for**
  - Fetal Fibronectin
  - Cytomegalovirus (CMV)
  - Bacterial Vaginosis
  - Parvovirus
  - Toxoplasmosis
  - Hypothyroidism

Added Care Processes

- Goal oriented prenatal visits
- Offer routine ultrasound at 16-20 wks
- Offer cervical stripping at 38 to 41 wks
- Offer screening for GBS at 36 wks

Goal Oriented Prenatal Visits

- Decrease overall number of visits
  - Visits occur at: 6-8, 10-12, 16-20, 24, 28, 32, 36, 38-41 weeks
- Ensures consistency
  - Appropriate goals covered at appropriate time
- Both provider and patient aware of what will occur and when
- Improve satisfaction

Routine Ultrasound

- Largely driven by consumer demand
- Has been cited in literature to:
  - Reduce post-date pregnancy
  - Earlier detection of abnormalities
  - No overall difference in morbidity or mortality
- 1992: 70% of all patients received at least one ultrasound in their pregnancy
- Strong recommendation for ultrasounds to be preformed and interpreted by qualified providers

Screening for GBS

- Recommended by Center for Disease Control to change from risk based approach to routine screening
- Intrapartum antibiotics for:
  - Positive cultures
  - Women who have had a previous child with early-onset GBS infection
  - Labor at < 37 weeks gestation
  - GBS bacteruria in the current pregnancy
  - Women with unknown culture status and with rupture of membrane >18 hours or maternal temp > 100.4 F

Cervical Stripping

- Offer women at 38 weeks with good dates
- Associated with:
  - Decreased post-date pregnancies
  - Decreased need for inductions
  - Possible decrease in post-partum hemorrhage
- No increase in neonatal or maternal morbidity or mortality

Tools

- Patient Tools
  - Pregnancy and Childbirth: A Goal Oriented Guide to Prenatal Care Binder
    - Self-administered Questionnaires
    - Consent Forms
    - Charts for: BMI, weight gain, nutrition, fetal movements
  - Pregnancy Brochures
  - Pregnancy Book

Tools

- Clinic Tools
  - Uncomplicated OB Patient Visit Calendar
  - BMI chart to be displayed near the weigh-in section
  - Breastfeeding reinforcement poster

Tools

- Provider Tools
  - Evidence-based CD-ROM
  - Documentation forms
    - Self-administered Patient Questionnaire
    - Antenatal Summary form
    - Master Problem List
  - Provider Pocket and 8X11Cards
  - Posters

6-8 Week Visit

- GOAL: Exchange information & identify existing risk factors
- Specific CPG recommendations:
  - Standardized screening
    - Abuse, genetic risks, pre-term labor risks
    - Appropriateness for CPG
  - Begin education
    - Pregnancy, Binder, Goal Oriented Visits

Absolute Contraindications

- Pre-existing diabetes
- Gestational hypertension/diabetes
- Fetal anomaly or abnormal presentation (> 36 weeks)
- Multiple gestation

Absolute Contraindications

- Placenta previa
- Chronic hypertension
- Systemic disease that requires ongoing care
- Drug abuse
- HIV infection

Relative Contraindications

- Age (<16 or > 40 years at delivery)
- Past complicated pregnancy
- Prior preterm delivery
- Prior preterm labor with hospitalization
- Preterm labor requiring admission
- Prior cervical/uterine surgery
- Intrauterine fetal demise

Relative Contraindications

- Fetal anatomic abnormality
- Abnormal fetal growth
- Abnormal amniotic fluid
- Second or third trimester bleeding
- Relative body mass index < 16.5
- Hematologic disorders
- Severe anemia (hematocrit < 24)
- Current mental illness requiring therapy

Relative Contraindications

- Cancer
- Seizure disorders
- Recurrent urinary tract infection, stones
- Substance use disorders
- Eating disorders
- Surgery
- Abnormal screens
- Abnormal maternal serum analyte test

10-12 Week Visit

- GOAL: Determine current health status & work towards a healthy pregnancy
- Specific CPG recommendations:
  - Offer genetic counseling if needed
    - Patient to receive ACOG brochure and consents with pregnancy binder
  - Continue education
    - Breastfeeding and exercise at every visit

16-20 Week Visit

- GOAL: Work toward a comfortable and safe pregnancy
- Specific CPG recommendations:
  - Offer ultrasound to all women
  - Continue education and add:
    - Signs to report
    - Triple screen
  - Repeat screening for preterm labor risk factors

24 Week Visit

- GOAL: Prevent preterm labor for a safe & healthy baby
- Specific CPG recommendations:
  - Continue education and add
    - signs of preterm labor
  - Screening domestic abuse

Abuse Screen

- Within the last year, or since becoming pregnant have you been hit, slapped, kicked otherwise physically hurt by someone.
- Within the last year has anyone forced you to have sexual relations?
- S.A.F.E.
  - Inquire about **Stress** and **Safety**
  - Ask if she is **Afraid** and **Abused**
  - Inquire about **Friends** and **Family**
  - Inquire about an **Emergency** Plan

28 Week Visit

- GOAL: Monitor progress and learn to count fetal movements
- Specific recommendations:
  - Labs:
    - 1 hour glucola screen to all women
    - Other labs based on indications
  - Continue education and add
    - Charting of fetal movements
  - Begin daily fetal movement counts
  - Begin assessment for signs of preterm labor until 36 weeks

32 Week Visit

- GOAL: Prepare for baby's arrival
- Specific recommendations:
  - Continue education
  - Repeat domestic abuse screen

36 Week Visit

- GOAL: Begin preparations for the hospital experience
- Specific recommendations:
  - Offer GBS screening to all women
  - Continue education

38-41 Week Visits

- GOAL: Prepare for delivery & baby's arrival at home
- Specific recommendations:
  - Offer cervical stripping
  - Begin post-date plan at 41 weeks
  - Continue education

Metrics

- Number of prenatal visits per patient
- Number of pre-term deliveries

- Number of post-term deliveries
- Number of neonates with GBS sepsis

Defense Authorization Act 2002

- Effects:
  - Eliminates our guaranteed obstetrical patient population
  - Women's health care may witness an exodus to civilian care
  - Exodus will likely be accompanied by an exodus of family members
  - Effects far beyond OB/GYN services

Preventing the Exodus

- Put our female clients first
- Additional funding is not the sole answer
- Know the competition
- Multifaceted fix

Uniform Product Line: 100% Implemented

- Family-centered care
  - Father, significant other, siblings invited and welcome to participate
- State of the Art, quality care
  - Follow the guidelines of the American College of Obstetrics and Gynecology, American Academy of Pediatrics, American Academy of Family Physicians, the American College of Nurse-Midwives, Association of Women's Health, Obstetric and Natal Nurses
  - Friendly patient and family centered staff
- Quality communication between patient and provider
  - Individualized birth plans
- Continuity of prenatal, perinatal and PP care by individual or team
  - Own doctor, who is part of a team that will know you and your medical needs
- Comprehensive personalized pain management
  - Epidurals or other appropriate anesthesia available
  - Post-partum pain management
- Safe, secure facilities
- JCAHO-accredited hospitals

Uniform Product Line: 80-90% Implemented

- Access to gynecological care within established standards
- Increased ease of getting appointments
- Individualized prenatal education
  - Classes, pamphlets, videos, websites
- Improved parking
  - Reserved or valet parking 3rd trimester and “Stork parking” after birth
- Mid-trimester ultrasounds
- Private rooms post-partum
- Lactation support programs
- Admission/discharge paperwork at bedside
- TRICARE & DEERS enrollment prior to discharge

Integrated Project Team Members

Mental Health & Women's Issues, Co Chair

Clinical Quality Program, Co Chair

Operations Directorate

Resource Management

Information Management, Technology & Reengineering Directorate

Communications & Customer Service Directorate

Acquisition Management

Office of General Counsel

Each Service Surgeon General representatives

IPT Objectives

- Delineate and track the uniform product
- Identify discrepancies from the uniform product and implement changes.
- Develop a two-pronged local and global marketing approach
- Develop metrics that track uniform product improvements and patient satisfaction.
- Improve and monitor the OB provider's level of satisfaction.

OB Initiatives: Quality Improvements

- Uncomplicated Pregnancy CPG
- Breastfeeding support
- Genetic counseling
- Patient education
  - Websites:
    - PregnancyAtoZ.com, Tricare.osd.mil, Healtheforces.org
  - Spring Garden CDs
  - Pregnancy & Childbirth Binder

OB Initiatives: Meeting Competition

- Full options for pain relief
- Birthing plans
- Mid-trimester ultrasounds

OB Initiatives: Increasing Convenience

- Goal Oriented Visits
- Improve appointment scheduling
- Satellite clinics
- After hour clinics
- Lessening administrative load
- Improved parking
- Early hospital discharge

OB Initiatives: Family Centered

- Facility renovations
- Digital baby pictures OB Initiatives
- Educational brochures in a variety of languages
- Involve family members

Marketing: Communicate Military Strengths

- Familiarity with military system
- JCAHO accredited hospitals
- Highly educated staff
- Experience in obstetrical care
- Choice of provider types
- Facilities around the world

Marketing

- Involve public affairs offices
- Identify strengths and market them
- Make accomplishments newsworthy
- Increase patient connectivity
- Market at every encounter
- All staff must be involved in marketing
- Use all available sources to market

Veteran Affairs

- Developed over 20 CPGs in collaboration with DoD
- Veterans' Health Care Eligibility Reform Act of 1996
  - Authorizes maternity benefits for enrolled women veterans
  - Relies on contract care to provide services
  - VA facilities may choose to provide antepartum and postpartum care and contract out only inpatient care
  - VA responsible for care delivered

Implementation

- Identify a clinical guideline champion
- Form multi-disciplinary implementation teams
- Use Plan, Do, Study, Act (PDSA) cycle
    - Identify gaps between current practice and CPG
    - Action plans targeting identified gaps
    - Education of all involved
    - Implement on small scale to test
    - Monitor outcomes
    - Provide feedback

Implementation: Leadership

- Essential resources
- Inspiration
- Motivation
- Prioritization of implementation
- Assistance with recruiting and support the Clinical Champion
- Accountability
- Facilitate action
- Note trends

Instructions for Securing CME/CHE Credit

- Log-0n to the web site: http://www.QMO.AMEDD.ARMY.MIL
- View the educational activity
- Sign-in
- Register online
- Complete the evaluation and post-test
- Print certificate

When the participant has completed these steps and successfully passed the exam a certificate will be awarded electronically

More Information

- AMEDD web site:
  - http://www.QMO.amedd.army.mil
  - Links to VA and AF POC's for tool kit reordering
- VA web site for guideline information:
  - http://www.oqp.med.va.gov/cpg/cpg.htm